

Transfer of accountability system ensures safe patient handoff

By Patti Cochrane

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Checking the status of the IV as part of the “five checks at the bedside” in Trillium Health Centre’s award winning Transfer of Accountability process are (left to right) Julie Santarossa RPN, patient Penny Gallier of Mississauga, and Rochelle Wuthrich RN.

Every 24 hours at Mississauga’s Trillium Health Centre, upwards of 1,500 information exchanges take place between two nurses at the patient’s bedside. One nurse is finishing a shift; the other has just started. Anyone in a hospital environment can appreciate the significance of this communication juncture, and the vital importance of transferring information that is clear, complete and accurate.

Such is the thinking behind Trillium’s Transfer of Accountability (TOA) initiative, also referred to as ‘safe patient handoff’. First implemented by Trillium’s orthopaedic unit in December 2008 and now in use hospital-wide, the TOA follows a standardized method of bedside reporting that improves communication among providers and involves patients more actively in their own care.

The transfer of accountability work supports Trillium’s Quality by Design strategy by providing timely and appropriate transfer of information amongst professional staff and meeting the standards from Accreditation Canada. “The implementation of the TOA is a good example of the Trillium culture,” says Trillium President & CEO Janet Davidson, O.C. “This patient-centred safety initiative came from the hearts and minds of the staff who wanted to ensure that the hand-off process for their patients was inclusive. We commend their efforts to safeguard our patients.”

The TOA process has the two nurses — one leaving and the other taking over — stand on either side of the patient’s bed. Speaking in gentle, low voices, (in part to help protect patient privacy), they introduce themselves and ask permission to conduct a verbal report in the patient’s presence. Upon receiving consent, they proceed to discuss information such as vital signs, clinical condition, abnormal findings, pending diagnostics and treatment, and the plan of care. Included in the process are five safety checks listed beside each bed: alarms, armbands, allergies, intravenous, and environment (identifying potential safety risks in the room).

“We saw an opportunity to improve patient safety and satisfaction,” says Kathy Elliott, manager of Orthopaedics at Trillium. “Each patient is party to a full change-of-shift report, two to three times a day. The patient gets to know each new nurse and witnesses the knowledge transfer.” Elliott adds that “patients love it,” while nurses appreciate the opportunity it provides to clarify information. So

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is the pain felt only when the patient is standing or is it all the time?... Is that what the wound looked like when you last changed the dressing?

Each exchange takes an average of three minutes — a key consideration given the fast pace and competing priorities of hospital work. Which perhaps begs the question: was there any resistance to it?

“All it takes is one close call and the nurses are sold,” says Kathy Elliott. “When a nurse walks into a room alone and finds a patient in distress, it can be pretty scary.” A brief meeting can prevent that situation, empowering the oncoming nurse and enabling the one leaving to do so with greater peace of mind.

According to Joint Commission on Accreditation of Health Care Organizations (JCAHO) research, communication failures account for over 60 per cent of the root causes of sentinel events. Hospital shift changes, moreover, are at high risk for miscommunication. In developing the TOA, therefore, Trillium looked at communication models used by other performance-critical organizations such as NASA and Canadian nuclear power plants. One of the common denominators among these entities is a read-back process, whereby information is always presented in the same sequence, and the person receiving it recites it to make certain it's been understood.

Drawing from these findings, and building on a system of safety checks used at Hamilton Health Sciences, Trillium included a full bedside report in the process. Hospital-wide working groups comprising nurse managers, directors, educators, and frontline staff developed TOA policies and procedures. Project champions helped provide in-the-trenches leadership in areas such as education, which, in addition to documented instruction, involved extensive role-playing.

In Trillium's cardiac surgery unit, the system has been customized to incorporate what staff call the “S.A.F.E.” reporting process: Story, Assessment, Follow-up, and Evaluation.

“Our goal was to provide a structured, interactive, collaborative communication between staff and their patients,” says Cecile Marville-Williams, manager of Trillium's Cardiac Services Patient Unit. “We've seen improvements in efficiency and effectiveness, as well as enhanced quality of patient care and increased patient and staff satisfaction.”

Trillium recently began surveying patients and the early returns are enthusiastically in favour of the new TOA. Ninety-five per cent (18 of 19 respondents) said they “feel safer” and “know what's going on”, and 84 per cent (16 of 19) indicated they “feel included” and “know their nurses better”. Family members, meanwhile, often plan their visits around shift-changes; a family member in attendance further improves the information-sharing.

Clearly, the new model is well-received at Trillium — while outside the hospital, it's garnering considerable industry attention: in June 2009 the Trillium TOA was recognized nationally with the BD Canada Health Care Safety Award from the Canadian College of Health Service Executives (CCHSE).

“We're very passionate about this,” says Elliott. “And the patients see that.” The bedside reporting, she says, gives them a clearer window into what nurses do and helps them see the scope and value of nursing services. “They realize how seriously we take our work — and that it allows no margin for error.”

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